Telling talking: discourse and practice in context

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Abstract
The paper explores the contribution that discourse analysis can make to understanding the unevenness of policy implementation. This aim is addressed through three questions regarding the relationship of discourse to actors and places: Do discourses map systematically onto identifiable constituencies of actors? Do discourses map systematically onto places in a way that has some coherency with the variation found in the performance of health care provision? Does patterning of discourse by place merely reflect local composition by constituencies of actors or is something more contextually specific at work? The study explores discourses relating to a programme of health reforms in the state of Ceará, Northeast of Brazil, a state strongly committed politically to the reform agenda. Three case studies of decentralised political units, the município*, are selected based on different settlement type (urban, metropolitan and rural) and differently performing health systems. Mapping various forms of argumentation shows clear association with identifiable constituencies within and between local health systems. However, the presence of different forms and combinations of discourses between the three case studies implies an influence of context beyond structural interests in shaping local cultures of practice. The relational and situated nature of discourse coalitions identified in this study makes clear that discourse analysis has to be used as an approach to understanding spatial differentiation in tandem with other methods, sources of data and types of analysis. However, discourse analysis may define the questions for those other approaches by acting as a probe to tease out issues.*

Introduction

Spatial variation resulting in unequal provision of health care is well recognised, the so-called postcode lottery (recent examples in the UK include Bungay, 2005; The King's Fund, 2006). Despite explicit targeted policies in many countries (see for example DHS, 2006), continued spatial variation is a major policy challenge in creating an equitable social welfare system. Whilst acknowledging that the causes of such spatial injustices are multiple, this paper explores the contribution of discourse analysis to understanding the unevenness of policy implementation. This aim is addressed through three issues regarding the relationship of discourse to actors and places: whether discourses map systematically onto identifiable constituencies of actors;

whether discourses map systematically onto places in a way that has some coherency with the variation found in the performance of health care provision; and whether a patterning of discourse by place merely reflects local composition by constituencies of actors or something more contextually specific at work.

The analysis is drawn from a study of the implementation of policy reforms in Northeast Brazil in the late 'nineties, comparing three local health systems in the state of Ceará: an urban, a metropolitan and a rural setting. The reforms included the decentralised management of health systems down to the third administrative tier in Brazil, the *município*. Decentralisation as a policy explicitly gives discretionary space for policy interpretation and practice to the local level and as such potentially presents a greater challenge to the delivery of spatially equitable health care as well as affording an excellent research setting in which to examine implementation as a differentiating process.

A significant body of research on policy implementation focuses on actors as the agents mediating between policy directives and policy practice (Ham, 1992; 1997; 2001; Ham et al., 1990). Debate centres on the relative importance of drivers of the constituent actors' behaviour: the influence primarily of personal or group interests, as in much of the principalagent approaches to policy implementation (Bossert, 1988); the influence of the structural position within a system as described originally by Alford (1975) and applied more recently to health systems by North and Peckham (2001); and the influence of more entrenched norms of behaviour or habit, not so easily displaced by shifts in incentives (March and Olsen, 1989; Coaffee and Healey, 2003). Thus Schattschneider's (1960) characterisation of all political organisation as the mobilisation of bias needs to allow not only for the exercise of power for overt or covert biases of interests but also those latent biases that come from a way of thinking or entrenched norms (Lukes, 1974).

Intimation of these 'biases' comes through actors' interpretations and meanings of policy directives and experiences. Access is gained through actors' own words, how they talk about both policy and practice and what that talking tells the analyst about the underlying interests and values. Open interviews and more informal conversations create a space for story-telling by individual subjects. In this study, these comprised the senior health system managers, the front-line health staff dealing directly with the user population, formal representatives of the *município* population serving on the local health council, local politicians, other local leaders, staff in other related sectors (such as education or social welfare), and other local residents.

The primary data are narratives on experience, practice and actions together with their interpretations, rationalisations and justifications with respect to the health reform agenda. From these individual narratives, the analyst can draw out individual story-lines on particular topics. These, in turn, are grouped by topic, facilitated by use of the QSR software (1997)

and analysed to identify a small number of types of story-lines broadly distinguished by underlying attitudes, elements and lines of argument. It is these abstracted underlying elements to broad types of story-lines that are treated here as a set of dominant discourses.

The term discourse has multiple definitions and forms of analysis marshalled to achieve very different purposes (Lees, 2004; Suurmond, 2005; Hajer and Versteeg, 2005). Here, following Hajer's work on discourse in political processes, discourse is treated as 'an ensemble of ideas, concepts, and categories through which meaning is given to phenomena' (1993: 45). Each dominant discourse is then mapped back onto the associated subjects in order to assess whether there is some pattern to membership of what Hajer has termed discourse coalitions (1993). The analysis thus aims to map the dominant discourses against identifiable interest groups, as defined by their structural position in the system. In this respect the research follows an established tradition across the social sciences in analysing policy formulation, policy partnerships and policy development (for example Hastings, 1996; 1999; Hønneland, 2004). The analysis is taken one step further by exploring whether these dominant discourses map systematically across the three different local health systems in a way that has some coherency with the variation found in the performance of health care provision and which may therefore contribute to understanding how spatially patterned differences and inequalities in health care provision are produced. Taking this understanding further requires analysis of whether the mapping of discourses spatially merely reflects different constellations of constituent actors in the local health systems or whether relationships between discourse, actors and practice are more profoundly embedded within context.

Health reforms and the study setting

Brazil, like many other South American countries, experienced a protracted period of military dictatorship for about a quarter of a century. During a time of repression of democratic and political organisations, political activism was channelled through apparently non-political organisations lobbying for needs and services at local level; in this, health and health care needs represented significant sites of struggle. The return to civilian rule has witnessed an expectation for policies to address and redress the long history of social injustices, massive inequalities and political control; health reform was central in this context and health care was declared a right for all in the new Constitution of 1988.

Prior to 1988, the health system was fragmented by both finance sources and providers. The public sector health care was divided between two ministries, the Ministry of Health and the Ministry of Social Security (INAMPS), with further services provided directly by *municípios*. The private sector was, and still is, a highly advanced and flourishing industry in which the best health care possible is available to those able to pay. A network of private-notfor-profit organisations provide much of the hospital based care in more disadvantaged areas.

The public system contracts services from the private sector, both for-profit and not-forprofit, and much political argument centres on this relationship. The primary structural change of the health reforms was to bring these various providers into one system, the single health system, or SUS (Sistema Unico de Saúde), managed by the Ministry of Health. The second major structural reform was decentralisation of management accompanied by increased popular participation.

The state in which this study is based was chosen because of its political commitment and early implementation of decentralisation. The Northeast of Brazil has been marked by a cultural and political history of clientelism and patronage, together with a strong role for the church in charity and philanthropy. Thus access to basic services has been viewed as granted through favour or charitable acts of goodwill rather than demanded as a right and the responsibility of those in political power (Queiroz, 1975; Faoro, 1979). In Ceará in 1986 a new political coalition of industrialists and business entrepreneurs won political control of the state government, identifying themselves with efficiency and modernisation (Lemenhe, 1999; Teixeira, 1995; Parente, 1992 and 1990; Carvalho, 1990), and campaigning under the slogans of "the fight for the end of *coronelismo*" (the specific term for the oligarchy in the Northeast of Brazil) and "a government of change". This coalition was strongly committed to economic, administrative and social reforms and made a major commitment to political decentralisation and health reform.

Three *municípios* and their local health systems were chosen to represent very different types of settlements within the state of Ceará.

- The rural case study was located in the dry interior of the state, the *sertão*. The settlement probably developed as a stopping off point for cattle being brought to the markets in the capital city of Fortaleza from further parts of the state. The rural economy is based on cattle, some agriculture, small-scale production of other agricultural products. Travel within the *município* is difficult; there is little public transport and few services other than in the central settlement. There are few social organisations other than those based around the church and the rural workers union. Health care provision at the time of the study was poor, virtually non-existent other than at the small central hospital and the activities of the community health workers. There was only a very small cadre of physicians and nurses employed in the *município,* mostly employed on part-time contracts with attendance by senior professionals available only on certain days at the health posts. Hardly any actually lived in the *município* and at the time of study, many of the senior personnel did not show up to fulfil their hours due to salary arrears and lack of accountability structures.
- The urban case study was a historically important interior town that had grown up around coffee plantations and trade. The town had had the first rail link in the state to

the capital city and was home also to what had once been a large, thriving Jesuit monastery on the outskirts. Located in the cooler hilly areas, the *serra*, the areas around the town attracted the capital city's middle classes for weekend breaks in their second homes (small-holdings or *sítios*) and the town itself had a noticeable resident middle class population in comparison with the rural case study. The economy in the rural areas around the town was quite mixed, with coffee still produced but with a wide range of other agricultural and animal based activities going on. Health care provision was good although still quite basic outside the central town. Here, many of the physicians lived in the town and had some kind of commitment to the place.

 The metropolitan area was a relatively recently settled area on the edge of the capital city, Fortaleza. It was highly densely populated with rail and bus transport links into the city. There was a growing industrial complex, a wholesale fruit and vegetable market, numerous retail outlets and a multitude of small-scale home-based enterprises. The health system had a network of relatively sophisticated services which were complemented by a parallel network of private providers in terms of clinics, hospitals and pharmacies. There was a large cadre of physicians and nurses with senior staff in attendance at the health centres every day for at least half a day, although problems with staff working short hours and absenteeism were reported. Health provision was good although all the centres were very busy and securing an appointment was a challenge for patients.

Dominant discourses and conflicting voices

The analysis identified five relatively common and distinguishable discourses: egalitarian; compassionate; professional; managerial; disempowered. Each of these tended to attach both to a definable constituency and to the specific context of a given case study *município.*

Egalitarian discourse

This discourse reflects and is based in the language of the health reform movement. The health reforms are argued to not only promote good quality health care for all but also to contribute to wider political change in promoting democracy and political voice throughout all strata of society. The moral superiority for the discourse and for the activities of the health reform process is claimed through the desire to see a more equal and just society. The tone of the discourse is not only egalitarian but has something heroic about it also. This was the dominant discourse at the State Secretariat of Health of Ceará, which had explicitly made a strong political commitment to the health reform agenda. Whilst some elements of the discourse were found everywhere, this is particularly associated with those health professionals who similarly have a history of involvement in the health reform movement and a current commitment

to the reform process. In our study, this discourse emerged as one of those dominant only at the Secretariat of Health in the urban case study.

'Municipalisation brings health closer to the community, moreover it breaks the absolute power of the physician, who now has to share power with the nurse, with the community health worker and with the community itself'

[Physician in the Secretariat of Health, urban case study].

'With municipalisation and the Council [local health council], the community comes to decide its needs, to meet to discuss the problems, the secretary [of health] no longer manages alone and makes the decisions, now everything has to go via the Council'

[Physician in the Secretariat of Health, urban case study].

The user representatives in the urban case study had picked up some of the reform jargon and expressions whilst also expressing their endorsement of this position in their own phrases. In this case study, the local population had a history of greater involvement in social movements, social organisations and so forth and a greater politicisation and engagement with the political aims of the health reform rhetoric.

'Municipalisation has made things better because it gave the right to health care to all without any distinction, before it was necessary to get a card from Funrural, from INPS [different agencies providing care in the fragmented system before reforms] or some other'

[Local health council lay member, urban case study].

'Municipalisation opened a space for participation, now they have a space where they can raise complaints, can be heard and the community is recognised'

[Local health council lay member, urban case study].

The explicit expression of commitment to the reforms and the justifications for the reforms is consistent with the observation of a greater effort to implement the reforms in spirit as well as by procedure that was characteristic of the urban case study. For example, only here was the municipal health council properly constituted and called to meet regularly, with a proper agenda and minutes and some clear ability to challenge and question the operations of the Health Secretariat.

Compassionate discourse

This discourse frames the health reforms not in terms of the aims with respect to wider justice in health care and social and political change, but in terms of the effects of the procedures of the reforms. This discourse focuses particularly on the financing system put in place and its

effects in limiting the numbers of paid consultations and hospital admissions. This is one of the major areas of debate, argument and struggle of different interested parties in Brazil and thus represents one of the major sites of struggle against the rhetoric of the egalitarian discourse. The ceiling that has been placed on the number of treatments that will be paid for is positioned as limiting the ability of the health providers to meet all the needs of an indigent population. The legitimation of the discourse comes from a language of moral superiority based on the desire to provide health care to all who need it, especially those most in need, those without an alternative to this service.

Those of us who try to work, of the philanthropic hospitals [the private not-for-profit sector] in a good honest way, in this sense have been suffering faced with all this strict financial management that the government is doing. Diminishing resources, cutting the AIHs [payments for hospital admission], you know? The people are suffering from this, the people are used to being well attended to, and here we are stuck in a dilemma between good provision of care and not providing care because we don't have an adequate maximum number of paid procedures. Stopping providing care in this hospital because the maximum has been cut. If we always just treat people, treat people, the day will come when we end up shutting the doors……. If the resources diminish, the people don't know that the resources have diminished and that the maximum number of paid procedures has also gone down, they don't know and that we have to stop treating them. And not knowing, they think that it's because of bad intent on our part…. Think that the hospital not wanting to treat is a pressure from us, when it's not like this at all' [Private NFP health professional, urban case study].

In the study, this discourse was dominant amongst the managers of private facilities contracted by the public system to provide services for the *município,* and particularly amongst the private-not-for-profit providers, the charitable, often religious foundations. Whilst both the urban and metropolitan case studies had private providers contracted as part of the local health system, this somewhat oppositional discourse mapped as one of the dominant discourses only in the urban case study, where the hospital was a private-not-for-profit religious run *Santa Casa*. Such hospitals are widespread across Brazil and it is likely that this example would be echoed in other similar sites, indeed such a discourse could be found regularly expressed through the state newspapers. The hospital was the only hospital in the urban case study and thus had a significant role and an important position of power in local health politics. Whilst the discourse does not represent full opposition to the reforms, by keeping a highly

interested eye on the financial aspects of the local health system, the discourse reflects a process through which the watch-dog behaviour of the opposition enhances the accountability of the Secretariat of Health. In this case, therefore, the oppositional nature of the discourse works as a complementary force to maintain and ensure the provision of good quality care.

Professional discourse

This discourse was couched in language of the health professional as a skilled practitioner whose primary concern is not about politics or wider social considerations, but first and foremost about providing a good quality of care for the catchment population of the health services and the network. The moral legitimation of this discourse is based in notions of professionalism such as conscientiousness, commitment to the profession, good quality skills and practice. The discourse can be seen as in part oppositional to the egalitarian discourse in that it is associated with a critique of the reforms that argues that there has been an associated drop in standards and in professional training.

I mean, today you have all that scrapped. If it was because the social insurance system wasn't working well, but those [hospitals] used to work fine and today, why is it they don't work well? The people that are really the fighters for SUS, they don't support in any way my manner of thinking but this is my manner of thinking….and what I believe is that what we don't have is the complementarity, that they shouldn't have messed with INAMPS, not with the social insurance system.

[Health professional, metropolitan case study].

The health system was working better, clearly. You used to trust the institutions, treatment was better I haven't the least doubt……..the physicians were paid better, if you're paid better you provide better treatment to the patients. They had a per capita salary, now they're paid by productivity……..if you have the inquisitiveness to look at the SUS tables [of payments], from that you can get rich much better with this, if you take any physician you'll see a receipt …..'

[Local councillor, metropolitan case study].

This discourse maps most clearly onto the cadre of health professionals who were previously employed through INAMPS. On the whole, these professionals had better terms of employment with greater perks and further training or refresher opportunities, advantages that they had maintained with the merger of the parallel systems, so the interests evident were more sophisticated than of simple personal gain. The INAMPS network had provided the better network of health care than the Ministry of Health and employment within INAMPS had held higher status. Whilst most of the senior health professionals now in management positions had

once been employed through the INAMPS network, this discourse mapped onto the metropolitan case study, rather than the urban case study, reflecting perhaps the greater absolute number of staff previously employed by INAMPS but also a greater number without a previous history of political commitment to the reform movement. The emphasis here on professional commitment and skills differentiates this discourse slightly from the other dominant discourse found in the metropolitan case study, although there are some overlaps in terms of treating health care as largely a technical rather than a political activity.

Managerial discourse

This discourse is characterised by emphasis on managerial outcomes such as effectiveness and efficiency. Similarly to the professional discourse, the focus is on the delivery of good quality care for the population; the difference here is the concern with population based and system based management goals rather than the emphasis on professional practice and behaviours. In neither of these discourses is there much room given to aspects of social development, which are largely expressed as outside the proper concerns of the health professionals and the health care systems.

'Here we have, for example, I think that this doesn't exist anywhere else in Ceará, not one other that has a cadre of professionals and workers, of physicians like the município *of [metropolitan case study]'*

[Local health system manager, metropolitan case study].

'The financing system is extremely complicated, even the accountants have difficulty to understand it, how can the local population be expected to. It's just a waste of people's time to call them to a meeting to view and approve the accounts. It's a nonsense and we shouldn't be wasting people's time like this'

[Local health system manager, metropolitan case study].

Despite dismissing the wider political goals of health reform, the moral superiority of the discourse comes from not wasting the population's time or money, providing the best value for money in a no-nonsense, goal-oriented approach. In this discourse, the professionals are public servants entrusted with the task of health care provision and the moral obligation is to do that in the best way possible. Here then, health care is removed from the political domain and treated as a technical activity. Again, this is an orientation shared in both the professional and the managerial discourse, the distinction being that the professional discourse focuses on individual clinical skills whilst the managerial focuses on system management skills. Again, similarly to the professional discourse, the managerial discourse maps as dominant in the metropolitan case study. This pair of complementary discourses is consistent with the provision of health care in the metropolitan case study which is characterised by a large network of

facilities, a high level of inputs of staffing and equipment resources, and a focus on expanding the diseases that can be monitored and treated at the health centres. Whilst provision was technically good, the relationship with the population was not seen as a prime concern and no channel for communication specifically on health was active at the time.

Disempowered discourse

This discourse was the one most removed from any connotations of equating to a kind of ideology. Here the discourse merely expressed a sense of powerlessness to do anything, a lack of morale or sense of possibility. This discourse was dominant in the rural area, particularly amongst the health professionals. Here the local prefect had taken control of the local health system and refused to hand over any control of resources to the local health system secretariat. As a result, most of the senior health professionals had left and those that remained had and expressed little control over anything.

'That is, when the moment comes to do something, where is the the resources to do it? ….we're stuck in an impasse……..you find the lack of money at the time to set anything up….it's not there, there aren't any resources now to do anything, now I think that it's a really important, serious thing and because of this I've changed political group….because I think that the Municipal Health Fund should be in the hand of the Secretariat of Health…..because the Director of the Hospital is the brother of the Prefect, he ended up controlling the Municipal Health Fund, that is not all of it, a part, he invested more in the small hospital and left public health activities uncovered, and I could find no space [to do anything] because when I came there was no longer any resources to allocate '
[Local health system manager, rural case study].

Similarly, although meetings involving the local population took place there was little sense expressed that this achieved anything. The wider population continued to look to political patrons for access to better quality health care further afield than that afforded locally in the *município.*

"We arrive at the communities and they say 'my son is ill'. Then we go to the local councillor and she gives us a car. (...) The local councillor, I must say, is the one we rely on the most here "
(Community health worker, rural case study).

"He [one of the senior Health professionals] asked me to say to anyone or any stranger who asks about the Association [Health Council] that it does exist. But I will not lie; the Association only exists on paper"

(Health Council lay representative, rural case study).

"The municipal health council in Caridade does not work well because the health council needs to control the municipal health fund but in Caridade it doesn't. The Health Secretariat does not control it either. How can we do something for the municipality? Here we have the health council but the Secretary of Health doesn't control the resources, so she can not take any action"

(Health Council lay representative, rural case study).

Indeed, the provision of health care was non-existent apart from at the small local hospital. Staff did not turn up to work, two of the health posts had effectively shut down and only the community health workers, who are contracted and paid for at the state level, were functioning effectively.

Discourse, actors and context

The paper set out to explore the contribution of discourse analysis to understanding unevenness in policy implementation through three descriptive issues.

Discourses and constituencies of actors

The first issue is whether discourses map systematically onto identifiable constituencies of actors. Research and theory on the processes of policy implementation lead to an expectation that the dominant discourses will be associated with identifiable constituencies of actors. In this study, the discourses do map onto identifiable constituencies of actors to some extent. The egalitarian discourse is associated with those politically committed to the reform agenda. The compassionate discourse is associated with the private-not-for-profit providers. The professional discourse is associated with those senior health professionals previously employed through the Social Welfare Ministry who may be seen to have lost institutional power and privileges under the reforms. The managerial discourse is associated with a cadre of senior health professionals neither in opposition to the reforms nor activist in their development. The disempowered discourse is associated with any group that feel they have no space to improve the provision of health care. These associated constituencies can in turn be seen in terms of interests (professional, compassionate), position in the system (managerial, disempowered) and entrenched norms (all of them to some extent).

However, this mapping is only partial. Many of the senior health professionals were formerly employed by the Social Welfare Ministry. These individuals are associated with the egalitarian, managerial and disempowered discourses, not only the professional discourse seen as expressing their loss of privilege. What instead appears to be the case is that the dominant discourses map well onto constituencies of actors only within the context of specific local

health systems.

Discourses, places and variation in health care provision

The second issue is whether discourses map systematically onto places in a way that has some coherency with the variation found in the performance of health care provision. In this study, there is a reasonable relationship between ensembles of ideas, concepts and categories used to give meaning that comprise the dominant discourses and the way that the health reforms are rolled out in each local health system. The metropolitan district is characterised by the dominance of the managerial and professional discourses, associated with and distinguishing two constituencies of senior health professionals. The practice of health care provision and the implementation of the reforms in a technical fashion is consistent with the values expressed through the discourses. Similarly, the dominance of the egalitarian discourse in the urban district is paralleled in the practice of health care provision more closely following the political democratising intent of the reform agenda. The compassionate discourse also evident in the urban context contests the value of the reform agenda at the same time as those articulating the discourse contest the reform agenda in practice also. The disempowered discourse goes hand-in-hand with the lack of space for health professionals or the population to affect health care provision.

However, what this correspondence between discourse and practice indicates with respect to implementation of policy is far more complex. It would be too simplistic to suggest that the dominant discourses represent or reflect mind-sets which determine how health care is practiced and how the reform agenda is implemented. The identification of discourses in this study has, amongst other things, explicitly focused on the arguments presented as moral legitimation of both political position and professional practice. These arguments drawn from the story-lines told by individuals to the researcher therefore are themselves instances of political practice and the dominant discourses identified similarly so. Thus, a nice distinction between the two is not sustainable and debate about whether discourse directs practice or *vice versa* is inherently circular.

Mapping discourse, composition and context

The third issue is whether patterning of discourse by place merely reflects local composition by constituencies of actors or something more contextually specific at work. The summary of the findings for the first two issues already demonstrates that the stronger mapping of dominant discourses by different spatial units than constituencies of actors supports an argument for the importance of the contextual specificities of place in the emergence of dominant discourses. The rural case study was the one most characterised by relationships of patronage and clientelism traditional to social structures of Northeast Brazil. This, combined with an

impoverished and spatially dispersed population, permitted the dominance of effectively two political groupings. These two alliances struggled for political power, and the various resources that accompanied that power, and effectively divided the *município* into two factions. In a setting with little infrastructure or facilities, the small hospital in the rural centre represented a highly visible political resource and both political factions kept it firmly under their control. Other health resources, such as drugs and ambulances, were similarly kept under the control of local politicians and access to them by the population seen as a favour to be repaid with political support. In this context, the strong sense of disempowerment reflects the disempowering nature of the traditional social relations in Northeast Brazilian society. The discourse then is produced and reproduced in the specificities of the rural case study which include the historical social relations, the contemporary reform expectations and the political potential of the health system resources. The urban case study shared the tradition of patronage, indeed members of the population spoke highly of previous prefects who operated in a personalised way, knowing people's names and so forth. The health system also had a highly visible small hospital in the urban centre with a dispersed population beyond this. What makes it so very different, both with respect to the dominant discourses and the performance of the local health system? Three aspects of the urban context seem to be significant. First, the urban *município* has a richer population. There is a sizeable middle-class and many of the health professionals working in the district also live there, at least part of the time. Thus, the professionals have a far greater investment in the place and a commitment to its future. Relatively little work has been done on the role of the middle-classes in health provision and the indications here are that this is a topic worthy of far greater attention. Secondly, the population itself is better politically organised. There is a greater number of local organisations than in the rural case study, moreover there has been previous experience of local councils managing projects and other developments. Lastly, the oppositional nature of the two dominant discourses in this case seemed to reflect a positive effect on performance. The oppositional discourse-interest group complex may have acted as a kind of watch-dog, keeping the local health system managers focused on providing good services.

The metropolitan case study had a much more diverse population, settlement types and provision of health care than either of the other two study sites. The combination of the two dominant discourses identified with the metropolitan case study depicts a local health system that has constructed a culture of health care practice and delivery based on a vision of health care as a technical activity. Elsewhere it has been argued that working with this kind of discourse can afford a space for local health systems to distance themselves from local politics in situations where this has little stability or does not favour the health sector (Atkinson et al., 2005a,b) again emphasising the emergence of discourse not only as strategy but as responding to contextual factors.

Particularly evident from this study is how dominant discourses at each site emerge in relation and in contestation to each other or a perceived hegemonic discourse. Notwithstanding the aims of the reforms to break previous power imbalances and health care injustices, for the purposes of this paper, the egalitarian discourse can be seen as in some ways hegemonic, the discourse of the policy-makers, certainly at the State level, and the discourse in response to which the other discourses can be seen as constructed. This discourse then is implicitly present in all the case study sites, but is only explicitly expressed in the context of the urban case study. Whilst this does reflect the presence of a particular interest group, that of health professionals with a history of political involvement in the health reform movement, their very presence and ability to act in this setting interacts with a history of a resident middle class including physicians, greater political organisation of the population, and a productive tension with the private sector (Atkinson, 2000). In turn, the compassionate discourse also clearly expressed the interests of a particular constituency within the context of national and state-wide reforms, those of the private providers contracted by the state and particularly the private-not-for-profit providers. Nonetheless, the particular context of the urban case study mapped this as a dominant discourse, which was not the case in the metropolitan area which similarly had a number of both private and private-not-for-profit providers. The category of private-not-for-profit is of course not homogeneous. The particular organisation in the urban area was a religious, Christian entity with a long history of working in that community and with that community which was not the case for the various private providers in the metropolitan case study. This may constitute an argument that the local composition of interest groups would explain the differential mapping of discourses if the categories were more refined, but it also demonstrates clearly the centrality of values rather than strictly interests as forming the discourse and its local expression. Lastly, the disempowered discourse again can be understood as constructed in part in reaction to the egalitarian discourse. The constituency of health professionals, for example, are aware of what policies and actions they might undertake, but are stymied by the lack of political empowerment on their side and the lack of political will from those in control. The disempowered discourse stresses the importance of absence in policy implementation in contrast to policy analysis that focuses on presence of power and interests.

The contribution of discourse analysis to implementation studies

The overall aim of the paper was to explore the contribution of discourse analysis in understanding the unevenness of policy implementation. The study from Northeast Brazil has demonstrated that discourses emerge in relation to one another and in relation to practice but that these relationships are strongly situated in the specific local contexts of the constituencies of actors or discourse coalitions. The study thus resonates with Hajer's exposition of an argumentative discourse analysis in which 'we do not simply analyse what is being said, but

also include the institutional context in which this is done and which co-determines what can be said meaningfully' (1995:2).

So what can discourse analysis contribute to exploring the complexities of policy implementation that contribute towards spatial unevenness in health care provision? On the one hand, the relational and situated nature of discourse coalitions identified in this study makes clear that discourse analysis has to be used as an approach to understanding spatial differentiation in tandem with other methods, sources of data and types of analysis. For example, understanding the situated processes in which constellations of dominant discourses, discourse coalitions and policy practice co-evolve requires a historical perspective to complement the empirical analysis. However, discourse analysis may define the questions for those other approaches by acting as a probe to tease out issues: the identification of discourse coalitions helps explore the extent to which these exert local or more diffused power and enables an analysis of local and wider strategies for mobilising bias; the moral legitimation offered in different discourses gives insights into more latent forms of power and bias residing in norms and values and the settings in which these can be expressed; the spatially differentiated mapping of discourses provokes further questions about the situated nature of policy implementation. The value of discourse analysis therefore does not, in this case, lie in its power to explain variation in health system performance through the meanings given to everyday practice. Rather, the identification of dominant discourses helps illuminate a reality of policy implementation that is both messy and localised and helps further probe the relations involved.

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